Outside of City Limits

STATE OF MARYLAND—CERTIFICATE OF DEATH

08600

1. PLACE OF DEATH (159)

County Allegheny Registration Dist. No. 4

Village or City Cumberland R-2 No. National Pike St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Infant - Atkins If U.S. Veteran specify WAR

(a) Residence: No. ___ St., ___ Ward. ___

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) Sept. 10 - 39.

7. AGE: Years | Months | Days | If LESS than 1 day, 1½ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Data deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) natl. Pike. R-2. (State or country) md

FATHER

13. NAME Henry H. Atkins

14. BIRTHPLACE (city or town) (State or country) Penna

MOTHER

15. MAIDEN NAME Jessie Fulkner

16. BIRTHPLACE (city or town) (State or country) md

17. INFORMANT Jessie Atkins (Address) Rt 2 Cumberland

18. BURIAL, CREMATION, OR REMOVAL Place Cumberland Date 9/11, 1939

19. UNDERTAKER Henry Atkins (Address) Rt-2 Cumberland

20. FILED 9/11, 1939 Joseph P. Frankin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 9 - (Month) 10 - (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 10 1939, to Sept 10, 1939

I last saw her alive on Sept 10, 1939; death is said to have occurred on the date stated above, at 7:15 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Premature infant 6½ months

Date of onset

Other Contributory Causes of Importance: Hydramnios

Name of operation ___ Date of ___

What test confirmed diagnosis? ___ Was there an autopsy? ___

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? ___

If so, specify ___

(Signed) Allen G. Murray M. D.

(Address) 41 [illegible]

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08601

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 165 W. Main

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 165 W. Main

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Christina Bowers

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife: William I. Bowers deceased

6(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): Aug 23 - 1856

8. AGE:

Years	Months	Days	If less than one day
83	0	21	——hrs. ——min.

9. Birthplace: Lonaconing Md.

(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Henry Meyers

13. Birthplace: U.S.A.

MOTHER — 14. Maiden name: unknown

15. Birthplace:

16. Informant: Joseph Bowers

Address: Frostburg, Md.

17. (Burial, cremation, or removal. Which?) burial Date thereof (month) (day) (year) Sept 16-1939

Cemetery or crematory: St. Michaels

Location: Frostburg, Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md

19. (Date rec'd by registrar) 9-16 1939 Registrar: Mrs. A. V. Walker

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13 1939, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1939 to Sept. 13 1939, and that I last saw her alive on Sept. 13 1939.

Immediate cause of death: Cardiac Dilitation — DURATION: Short time

Due to: Arterio-Sclerosis — DURATION: Unknown

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. C. Cohen M. D. or other

Address: Frostburg Date signed 9-15-39

RECEIVED
OCT 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (158)

Reg. Dist. No. 9

CERTIFICATE OF DEATH

08602

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Zihlman (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓

(e) Length of stay in this community (yrs., mos., or days) ✓

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Zihlman (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Virginia Carder

3 (b) If veteran, name war ✓

3 (c) Social Security No. ✓

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1939

8. AGE: Years — Months — Days 20 If less than one day — hr. — min.

9. Birthplace Zihlman (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Robert C. Carder

13. Birthplace Glencoe, Penna.

MOTHER 14. Maiden Name Virginia Lee Long

15. Birthplace Boden Shaft, Md.

16 (a) Informant Robert C. Carder

(b) Address Zihlman, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-8-39 (month) (day) (year)

(c) Cemetery or crematory Allegany Cem.

Location Frostburg Md.

18 (a) Funeral director Father A. L. Carder

(b) Address Zihlman

19 (a) 9-8-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 7 1939 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1939, to Sept. 7 1939, and that I last saw him alive on Sept. 6 1939.

Immediate cause of death Inanition — Duration 20 days

Due to The inanition existed from birth. C.W.G.R.

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. C. Cohen M. D. or other

Address Frostburg, Md. Date signed 9-7-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 3 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-C)

CERTIFICATE OF DEATH

08603

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Liberty Theatre

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 113 North Lee Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: MARIE L. CONDON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 4, 1881

8. AGE: Years: 58 | Months: 4 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Eckhart, Maryland (Town, county, and state)

10. Usual occupation: Retired seamstress

11. Industry or business: Footer's Dye Works

FATHER — 12. Name: William Condon

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Catherine Moriarity

MOTHER — 15. Birthplace: Ireland

16. Informant: Mrs. J. W. Reynolds

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 8, 1939 (month) (day) (year)

Cemetery or crematory: St. Patrick's Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Sept 7 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5 1939, at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from I did not attend patient while alive, 19, and that I last saw her alive on 19.

Immediate cause of death	DURATION
Acute myocardial failure	9-5-39
Due to Chronic myocarditis	About 6 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Anthony T. Jones M. D. M. D. or other

Address: 46 N. Liberty St. Date signed 9-6-39

CEIVED
OCT 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 6

CERTIFICATE OF DEATH

08604

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Westernport, Md. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: The Reeves Clinic

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State W Va (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Girl Cox

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1939

8. AGE: Years | Months | Days | If less than one day: hr. min.

Stillborn

9. Birthplace Westernport, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Odra Lender Cox

13. Birthplace Vanderlip, W. Va.

MOTHER

14. Maiden Name Hazel Va. Jewell

15. Birthplace Moorefield, W.Va.

16 (a) Informant Hazel Va. Cox

(b) Address Vanderlip, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16, 1939 (month) (day) (year)

(c) Cemetery or crematory Cox's Cemetary

Location Vanderlip, W. Va.

18 (a) Funeral director Odra Lender Cox

(b) Address Vanderlip, W. Va.

19 (a) Sept. 16, 1939 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 16, 1939, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16- 1939, to 9-16- 1939, and that I last saw him alive on 19.

Immediate cause of death	Duration
Stillborn	
Due to	
Due to Death of fetus about	9-1-39
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Norman Reeves M D (M. D. or other)

Address Westernport, Md. Date signed 9-16-39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(131)

WILMIN CORPORATE LIMITS

086059

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 93 W. Main

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William Craze (rare)

3. (b) Social Security Number: 220-03-7966

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 7 - 1881

8. AGE: Years 58 | Months 2 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace: England
(Town, county, and state)

10. Usual occupation: labor

11. Industry or business

FATHER
12. Name: Wm H. Craze
13. Birthplace: England

MOTHER
14. Maiden name: Mary E. Bond
15. Birthplace: England

16. Informant: Morris Craze
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 25-1939 (month) (day) (year)

Cemetery ~~or crematory~~: Allegany

Location: Frostburg

18. Funeral director: J. J. Durst
Address: Frostburg Md.

19. 9-26 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Probably about Sept. 18th 1939, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Chronic Myocarditis found dead in a garage where he was in habit of sleeping - body badly decomposed - was an alcoholic

DURATION

Due to

Due to

Other conditions: Chronic nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Linnes H. Corson, M.D.
M. D. or other

Address: Cumberland, Md. Date signed 9-25-39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1938
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08606

93-a

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
61 Broadway

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 61 Broadway
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Maurice Jack Delaney

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Child.

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1938

8. AGE:

Years	Months	Days	If less than one day
1	0	2	hrs. min.

9. Birthplace Frostburg Md (Alleg Co.)
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Joseph Delaney
13. Birthplace Frostburg, Md.

MOTHER
14. Maiden name Veronica Shuck
15. Birthplace Lonaconing, Md.

16. Informant Joseph Delaney.
Address 61 Broadway - Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29 1939 (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg, Md.

18. Funeral director Jacobs & Hafer.

Address Frostburg Md

19. 9-29th 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1939, at 6:35? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1939 to Sept 26 1939, and that I last saw him alive on Sept 26 1939.

	DURATION
Immediate cause of death Acute Myocarditis	3 wks
Due to ? ? ?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Shane Jr. M.D.
M. D. or other

Address Frostburg Md Date signed Sept 28 1939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 3 1939
U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(46B)

08607

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 541 Arnett Terrace

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 25 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No. —
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 541 Arnett Terrace
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Mrs Susanna De Vore

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ John W. (Deceased)

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) January 6 - 1862

8. AGE: Years 77 Months 8 Days 18 If less than one day ____ hrs. ____ min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business —

FATHER
12. Name Alexander Emerick
13. Birthplace Penna

MOTHER
14. Maiden name Elizabeth Leydig
15. Birthplace Penna

16. Informant Miss Effie De Vore
Address Cumberland, Md.

17. Burial (Burial, ~~cremation~~, or ~~removal~~. Which?) Date thereof Sept 27-39 (month) (day) (year)

Cemetery or ~~crematory~~ Hillcrest Burial Park

Location Cumberland, Md

18. Funeral director V. L. Temperaur.
Address Cumberland, Maryland.

19. Sept. 27 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1939, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug Sept 21 1939, to Sept 24 1939, and that I last saw her alive on Sept 21 1939.

Immediate cause of death: Malnutrition 1 month

Due to Cancer of stomach

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: Unknown

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE B. M. Schindler M.D. M. D. or other

Address 41 Arnett Date signed Sept 26 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

08608

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 5 DAYS
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. Va. County Hampshire
City or town Romney Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR World War.

3. (a) FULL NAME
DOUGLAS, MERVIN MR.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6 (b) Name of husband or wife TAYLOR, ELSIE
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 4, 1889

8. AGE: Years	Months	Days	If less than one day
50	5	18	hrs. min.

9. Birthplace W.VA.
(Town, county, and state)
10. Usual occupation WAITER, DEAF SCHOOL
11. Industry or business AT ROMNEY, W.VA.
FATHER 12. Name DOUGLAS, DANIEL
13. Birthplace W.VA.
MOTHER 14. Maiden name JOHNSON, RACHEL
15. Birthplace W.VA.
16. Informant MEMORIAL HOSPITAL
Address
17. ~~Sept.~~ Burial Date thereof Sept. 25 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Franklin, W.Va.
Location Franklin, W.Va.
18. Funeral director F.R. Brown
Address Franklin W.Va.
19. Sept. 25 1939 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

DR. GRACIE

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 22, 1939, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1939 to Sept 22 1939, and that I last saw him alive on Sept 22 1939.

Immediate cause of death	DURATION
Intestinal Obstruction	
Due to Strangulated femoral hernia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. G. Gracie M. D. or other
Address Cumberland Md. Date signed 9/25/39

RECEIVED
SEP 30 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

CERTIFICATE OF DEATH

08609

1. PLACE OF DEATH:

(a) County: Allegany

(b) City or town: Cumberland
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Memoral Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days):

(e) Length of stay in this community (yrs., mos., or days):

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State: Pennsylvania (b) County: Bedford Co

(c) City or town: Artemas Pa
(If outside city or town limits, write RURAL and give town)

(d) Street No.:
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** William.F.Elbin ~~Baby~~

3 (b) If veteran, name war: ..

3 (c) Social Security No.: ..

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: ..

6 (b) Name of husband or wife: Non

6. (c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 6, 1938

8. **AGE:** Years: | Months: 11 | Days: 23 | If less than one day: ____hr. ____min.

9. Birthplace: Pa
(Town, county, and state)

10. Usual occupation: Non

11. Industry or business: non

FATHER

12. Name: Stewart.Elbin

13. Birthplace: Pa

MOTHER

14. Maiden Name: Vera. Miller

15. Birthplace: Pa

16 (a) Informant: Memoral Hospital

(b) Address: Cumberland. Md

17 (a) Burial
(Burial, cremation, or removal)

(b) Date thereof: Oct. 1, 1939
(month) (day) (year)

(c) Cemetery or crematory: Artemus Cem.

Location: Artemus, Penna.

18 (a) Funeral director: Ephriam Smith

(b) Address: Artemus, Penna.

19 (a) Sept. 29/1939
(Date rec'd by registrar)

(b) J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. Date of death: September 29 19 39 at 8-55 aM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1939, to Sept 29 1939, and that I last saw him alive on Sept 28 1939.

Immediate cause of death	Duration
Intussusception	
ostruction	
Due to Intussception	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Operated
Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence:

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury:

23. Signature: W. G. Goetz
M. D. or other

Address: Cumberland Date signed: Sept 29 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08610

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days): 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 113 Offutt Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William Fleegle

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 24, 1938.

8. AGE: Years: 1 | Months: 1 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: --

11. Industry or business: --

FATHER — 12. Name: Lloyd Fleegle

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Ethel Bennett

MOTHER — 15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6, 39 (month) (day) (year)

Cemetery or crematory: Abe Cemetery

Location: Wileys Ford, W. Va.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Sept. 5 19 39 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

Dr. VanOrmer

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-4-39 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-3-39 19 to 9-4-39 19, and that I last saw him alive on 9-4-39 19.

Immediate cause of death	DURATION
Influenza	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Alfred VanOrmer M. D. or other

Address: Cumberland, Md. Date signed: 9-5-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

08611

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

(M)

(S)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Piedmont Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 33 Jones St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Baby Fredlock

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 6 1939

8. AGE: Years | Months | Days | If less than one day

Stillborn ____ hrs. ____ min.

9. Birthplace: Cumberland, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: W. Harold Fredlock
13. Birthplace: Piedmont, W.Va.

MOTHER
14. Maiden name: Kathleen Bissett
15. Birthplace: Piedmont, W.Va.

16. Informant: W. Harold Fredlock

Address: Piedmont W.Va.

17. ~~Westernport Md~~ Burial
(Burial, cremation, or removal. Which?)

Date thereof: Sept 8 1939
(month) (day) (year)

Cemetery or crematory: Philos cemetery

Location: Westernport Md

18. Funeral director: W. H. Fredlock

Address: Piedmont W.Va.

19. Sept. 8 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6/39 19 ____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6/39 19 ____, to Sept. 6/39 19 ____, and that I last saw her alive on Sept 6/39 19 ____.

Immediate cause of death: Premature Separation of Placenta

Due to: Transverse position - Cord presenting in Vagina

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: J. H. Armhead M. D. ~~or other~~

Address: 41 - Green St. Cumb. Md. Date signed: Sept 7/39

RECEIVED
OCT 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (50) Reg. Dist. No. 6

CERTIFICATE OF DEATH

08612

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Westernport (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 104 Main St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 82 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Westernport (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Main St. (If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Margaret Lannon Griffin

3 (b) If veteran, name war ✓ | 3 (c) Social Security No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John F. Griffin

6. (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1857

8. AGE: Years 82 | Months 9 | Days 26 | If less than one day _____ hr. _____ min.

9. Birthplace Westernport, Allegany Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Peter Lannon
13. Birthplace Unknown

MOTHER
14. Maiden Name Winifred Lannon
15. Birthplace Ireland

16 (a) Informant Patrick F. Griffin
(b) Address Westernport, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23, 1939 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Westernport, Md.

18 (a) Funeral director D. J. Boaz
(b) Address Barton, Md.

19 (a) Sept 22, 39 (Date rec'd by registrar) (b) Grayson Baker M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 21, 1939, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1939 to Sept 21 1939, and that I last saw him alive on Sept 21 19 39.

Immediate cause of death	Duration
Pulmonary Edema	1 day
Due to Carcinoma of left breast & Chest	4 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman Reese M.D. M. D. or other
Address Westernport, Md Date signed Sept 22 1939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
OCT 4 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH (8)

08613

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 223 Baltimore Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Hedrick (Stillborn)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1939

8. AGE: Years: Stillborn | Months | Days | If less than one day: hrs. min.

9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Dr. O. Ray Hedrick
13. Birthplace Grafton, W. Va.

MOTHER
14. Maiden name Hilda Dankie
15. Birthplace Benwood, W. Va.

16. Informant Dr. O. Ray Hedrick
Address Cumberland, Md. - 223 Balto. Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 7 1939 (month) (day) (year)

Cemetery or crematory Blumont Cem.

Location Grafton, W. Va.

18. Funeral director Jacob Hafer
Address Cumberland, Md.

19. Sept. 6 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1939, at 2:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6 1939 to Sept. 6 1939, and that I last saw h[illegible] alive on Stillborn 19

Immediate cause of death	OURATION
Intrauterine Asphyxia	9-6-39
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M. D.
M. D. or other

Address 402 N. Liberty St. Date signed 9-6-39

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(50)

08614

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 13 Days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 227 FAYETTE ST.
(If rural give LOCATION)

2(o) IF VETERAN, NAME WAR

3. (a) FULL NAME MRS. KATHERINE HEINTZ

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife JOHN LEWIS HEINTZ

6(c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) AUG. 26 1862

8. AGE: Years 77 Months 0 Days 27 If less than one day ___ hrs. ___ min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name JOHN PFEIFFER
13. Birthplace GERMANY

MOTHER
14. Maiden name MARY WINK
15. Birthplace GERMANY

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/25/39 (month) (day) (year)

Cemetery or crematory Rose Hill Mausoleum

Location Cumberland Md

18. Funeral director William H. Kight
Address Cumberland Md

19. Sept 25 1939 (Date rec'd by registrar) Jos. P. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 23 1939 5:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to SEPT 23, 1939, and that I last saw her alive on SEPT. 23, 1939

Immediate cause of death Carcinoma bath breasts — metastasis in chest and all over body

Due to

Due to Badly neglected Hidden by patient.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Slaughting breasts removed

Of autopsy no.

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A H Hawkins 39 M. D. or other

Address Cumbd Date signed 9-24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. HAWKINS

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(23)

08615

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 408 Broadway

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 408 Broadway
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Mrs. ~~SABINA~~ Swannah ELLEN HENRY

3. (b) Social Security Number: -

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Albert Henry

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 29, 1863

8. AGE:

Years	Months	Days	If less than one day
76	4	3	____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Samuel Tennell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: William C. Henry
Address: Oldtown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 3, '39 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: U.S. Route 51, East of Cumberland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Sept 3, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. Eliason

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1 1939, at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1939, to Sept. 1 1939, and that I last saw her alive on Sept 1 1939.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 10 yrs
Cerebral Embolism — 6 Mos.

Due to: Endocarditis — 3 yrs.

Due to:

Other conditions:
(Include pregnancy within 8 months of death)

Major findings:
Of operations:
Of autopsy: no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. W. Eliason MD
M. D. or other

Address: 126 Yuen St. Cumberland Md Date signed: 9/2/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Mrs. Sabina Ellen Henry

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

Reg. Dist. No. 4 08516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 3 days
Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 316 Bond Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: KATHERINE AGNES HEWITT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Thomas Hewitt
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5, 1870

8. AGE:

Years	Months	Days	If less than one day
69	3	29	hrs. min.

9. Birthplace: Broden Shaft, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: Thomas Hewitt
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Margaret Firely
15. Birthplace: Pennsylvania

16. Informant: David E. Hewitt
Address: 58 S. Carrollton Ave, Balto, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 6, 1939 (month) (day) (year)
Cemetery or crematory: St. Michials Cem.
Location: Frostburg, Md.
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19 Sept 5 39 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

Dr. ~~Van Ormer~~ Zimmerman

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-3-39, 19, of M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-26-39, 19, to 9-3-39, 19, and that I last saw h alive on 9-2-39, 19.

Immediate cause of death: pneumonia — DURATION: 2

Due to: Ch. Nephritis

Due to:

Other conditions: Hypostatic Pneumonia

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. Zimmerman M. D. or other
Address: Cumberland, Md. Date signed

Katherine A. Hewitt

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08617

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 202 Maple Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 202 Maple Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: ABRAHAM BLOOM HOOVER

3. (b) Social Security Number: 214-05-5196

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Marion E. Lancaster
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 4, 1873

8. AGE: Years: 66 | Months: 4 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Clearfield Co., Penna. (Town, county, and state)
10. Usual occupation: Brickworker
11. Industry or business: Pen*Mar Tile & Brick Co.

FATHER
12. Name: William P. Hoover
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Elizabeth McKee
15. Birthplace: Pennsylvania

16. Informant: Mr. Shannon W. Hoover
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 8, 1939 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Sept. 7 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5, 1939, at 4P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1939, to Sept. 5, 1939, and that I last saw h-- alive on Sept. 3, 1939.

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — DURATION: 1935
Due to: Chronic Myocarditis
Due to: Sudden Death.
Other conditions: Coronary Thrombosis — 9/5/39
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Clay L. Durrett M. D. or other
Address: Cumberland, Md. Date signed: Sept. 6, 1939

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(15721)

08618

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 0

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 206 Thomas St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Girl Hochard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1939

8. AGE: Years | Months | Days | If less than one day 1 hrs. min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Mr. Thomas Hochard

FATHER 13. Birthplace Vindex, Md.

MOTHER 14. Maiden name Dorothy Louise Stuart

MOTHER 15. Birthplace Cumberland, Md.

16. Informant Mr. Thomas Hochard

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20, 1939 (month) (day) (year)

Cemetery or crematory St. Patrick's Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Sept. 19 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1939, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from At birth 19 to 19,

and that I last saw h alive on Sept 15 1939

Immediate cause of death Congenital Hydrocephalus & Spina Bifida — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. C. Barnes M.D. M. D. or other

Address Cumberland Md Date signed 9-16-39

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08619

(93-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 36 Browning Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 36 Browning Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR --

3. (a) FULL NAME Wm. N. House Willaim N. House

3. (b) Social Security Number 212-18-1351

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Henrietta Roberts

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 24, 1871

8. AGE: Years 68 Months 0 Days 7 If less than one day ____ hrs. ____ min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation ~~none--invalid~~ Laborer

11. Industry or business Gen'l Textile Mills, So. Cumberland, Md.

FATHER 12. Name William House

13. Birthplace West Virginia

MOTHER 14. Maiden name Jane Ambrose

15. Birthplace West Virginia

16. Informant Mrs. Ralph Thuss

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal) Date thereof Sept. 4, 1939 (month) (day) (year)

Cemetery or crematory ~~Magnolia, W.Va.~~ Hillcrest Cemetery

Location ~~Magnolia, West Virginia~~ Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Sept. 4, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1939, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1939, to Sept 1 1939, and that I last saw him alive on Sept 1 1939.

Immediate cause of death Chronic Myocarditis — DURATION about 3 yrs.

Due to Arterio sclerosis

Due to Coronary Thrombosis — 1 hr

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury none Injured at work? no

23. SIGNATURE M. G. Bowen M.D. or other

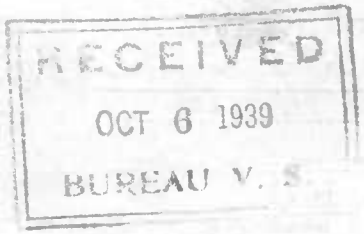
Address 133 Va Ave Date signed Sept 1 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

William N. House



WITHIN CORPORATE LIMITS.

08620

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(82a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 215 Humbird Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 215 Humbird Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: BENJAMINE PARKER HUFF

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sabre Jane Bucy

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 11, 1867

8. AGE: Years: 72 Months: 6 Days: 22 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: B. & O. Railroad

FATHER 12. Name: William Huff

13. Birthplace: Maryland

MOTHER 14. Maiden name: Margaret Crabtree

15. Birthplace: Maryland

16. Informant: Mrs. Alfred George

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: September 5, 39 (month) (day) (year)

Cemetery or crematory: Mt. Herman Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Sept. 5 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1939, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1938, to Sept 2 1939, and that I last saw him alive on Sept 2 1939.

Immediate cause of death: Arterio sclerosis

Due to: Cerebral Apoplexy

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: no operation

Of autopsy: no autopsy

DURATION: about 1934

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. E. B. Owens M. D. or other

Address: 133 Va Date signed: Sept 4 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 8

08621

CERTIFICATE OF DEATH

(82a)

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Gilmore
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓

(e) Length of stay in this community (yrs., mos., or days) 49 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Gilmore
(If outside city or town limits, write RURAL and give town)

(d) Street No. ✓
(If rural give location)

(e) If foreign born, how long in U. S. A.? ✓ years

3 (a) FULL NAME Jennie Yaste Jenkins

3 (b) If veteran, name war ✓

3 (c) Social Security No. ✓

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William James Jenkins

6. (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) March 8, 1870

8. AGE: Years 69 | Months 6 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Grantsville Garrett Co. Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER
12. Name James Yaste
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah Harden
15. Birthplace Maryland

16 (a) Informant Wm. Jas. Jenkins
(b) Address Gilmore, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27, 1939 (month) (day) (year)
(c) Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.

18 (a) Funeral director M. Eichhorn
(b) Address Lonaconing, Md.

19 (a) Sept. 27-1939 (Date rec'd by registrar) (b) Dr. E. Orr Flor Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 25 1939, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1939, to Sept. 25 1939, and that I last saw ~~him~~ her alive on Sept. 23 1939.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. M. Shelton, Jr. M.D.
M. D. ~~or other~~

Address Midland, Md. Date signed 9-26-39

VS. A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08622

CERTIFICATE OF DEATH

(34)

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 123 Frederick Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 73 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 123 Frederick St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME ELIZABETH JUNE JONES

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Colored ~~White~~

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James Ed. Jones

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1866

8. AGE:

Years	Months	Days	If less than one day
73	0	17	____ hrs. ____ min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Jerry Hymes
13. Birthplace: ??

MOTHER
14. Maiden name: Sarah ??
15. Birthplace: ??

16. Informant: Rodger Jones
Address: Cumberland, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Sept. 30, 39 (month) (day) (year)

Cemetery or crematory: Sumner Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Sept. 29 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1939, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-10 1936, to 9-27 1939, and that I last saw her alive on Sept. 15 1939.

Immediate cause of death: Aortic Regurgitation

DURATION

Due to: Syphilis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE J. S. Langston
M. D. or other

Address 5 Pr. Mechanic St. Date signed 9-28-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(154)

08623

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
627 Fairview Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 627 Fairview
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Theresa Kastner

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13 1885

8. AGE: Years 53 | Months 9 | Days 25 | If less than one day ___ hrs. ___ min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business

FATHER 12. Name Anthony Kastner

13. Birthplace Germany

MOTHER 14. Maiden name Mary Dalberga

15. Birthplace Germany

16. Informant Mary Kastner

Address 627 Fairview Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 11, 1939 (month) (day) (year)

Cemetery or crematory St Peter & Paul

Location Cumberland, Md

18. Funeral director Louis Stein Inc

Address Cumberland, Md

19. 9-11-39 (Date rec'd by registrar) Jos. S. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1939, at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1st 1939, to Sept 8 1939, and that I last saw h er alive on Sept 8 1939.

Immediate cause of death Osteomyelitis of Mandible — DURATION 5 wks

Due to Infected Gauze + Cadaveric Matter

Due to

Other conditions Exhaustion & Fast & arch terminal Meningitis 4 days
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. C. Barnes M.D.
M. D. or other

Address Cumberland Md Date signed 9-9-39

Dr Bowen

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82a)

CERTIFICATE OF DEATH

08624

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegheny

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 175 Old Town Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 175 W. Old Town Road (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Lettie Kerns

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6 (b) Name of husband or wife Late Jesse Kerns

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) February 20, 1867

8. AGE: Years 72 | Months 6 | Days 15 | If less than one day ____ hrs. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Daniel Grey

13. Birthplace Maryland

MOTHER 14. Maiden name Margaret Himes

15. Birthplace Maryland

16. Informant Daniel S. Grey

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9 1939 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland

18. Funeral director Virgil L. Lebpaseur

Address 207 Greene Street

19. Sept. 8 39 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1939, at 5.10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 6 1939, to Sept 7 1939, and that I last saw h[illegible] alive on Sept 1939

Immediate cause of death	DURATION
Cerebral Apoplexy	5 hrs
Due to age	
Due to Cerebral Apoplexy	1/2 day
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M E Bowman M. D. or other

Address 133 Va Ave Date signed 9/7/39

RECEIVED
OCT 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 7

(159)

CERTIFICATE OF DEATH

08625

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Barton

(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 40 hrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Allegany

(c) City or town Barton

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Baby Girl Kirkwood

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Baby

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept - 19 - 1939

8. AGE: Years | Months | Days | If less than one day 40 hr. ____ min.

9. Birthplace Barton - Allegany - Md -

(Town, county, and state)

10. Usual occupation Baby

11. Industry or business

FATHER

12. Name George J. Kirkwood

13. Birthplace Lonaconing Md

MOTHER

14. Maiden Name Leona Kimble

15. Birthplace Barton, Md.

16 (a) Informant George Kirkwood

(b) Address Barton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-19-39 (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location Lonaconing Md

18 (a) Funeral director Parker

(b) Address

19 (a) Sept 19 (Date rec'd by registrar) (b) S. A. Bouchelle Registrar

MEDICAL CERTIFICATION

20. Date of death Sept - 19 1939, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1939, to Sept 19 1939, and that I last saw ~~him~~ her alive on Sept 19 1939.

Immediate cause of death Premature 7½ months — Duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury none

23. Signature P E Berry M.D. M. D. or other

Address Piedmont W. Va. Date signed 9/19/39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

CERTIFICATE OF DEATH

08626

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Allegany Hospital.

Stay in hospital or inst. (yrs., or mos., or days) 20 hrs.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 256 Columbia St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Girl Knight

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9.19.39

8. AGE:

Years	Months	Days	If less than one day
			20 hrs. min.

9. Birthplace Cumberland, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name William Merrill Knight

13. Birthplace Bedford Co. Pa.

MOTHER

14. Maiden name Eileen Rosella Wassen

15. Birthplace Hagerstown Md

16. Informant Mr. William Knight

Address 256 Columbia St.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Sept 20 1939 (month) (day) (year)

Cemetery or crematory Prospect Cem.

Location Allegany Co. Md.

18. Funeral director Father

Address 256 Columbia St.

19. Sept 20 1939 (Date rec'd by registrar) Jos. P. Frankhouser M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1939, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1939, to Sept 19 1939, and that I last saw her alive on Sept 19 1939.

	DURATION
Immediate cause of death: Prematurity (About 30 weeks gestation)	9-19-39
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other

Address 40 N. Liberty St. Date signed 9-20-39

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

08627

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 12 Pennsylvania Avenue

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 12 Pennsylvania Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: STEPHEN E. KNOTTS

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillia Rice

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 3, 1869

8. AGE: Years 70 Months 7 Days 2 If less than one day: hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Switchman

11. Industry or business: B. & O. Railroad

FATHER
12. Name: Leneis Knotts
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Serena Bolyard
15. Birthplace: West Virginia

16. Informant: Walter A. Knotts
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 8, 1939 (month) (day) (year)

Cemetery or crematory: Mt. Herman Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Sept. 7 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

On E Owens.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 1939, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 37, to Sept 5 1939, and that I last saw him alive on Sept 5 1939.

Immediate cause of death: Chronic Interstitial Nephritis Arteriosclerosis

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: no

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of:

Where did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: — Injured at work?

23. SIGNATURE: M E B Owens M. D. or other

Address: 133 Va Ave Date signed: Sept 6 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08628

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 2 Days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town VINDEX Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME BABY RONALD KNOX

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 26, 1938

8. AGE: Years | Months 9 | Days 22 | If less than one day hrs. min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name RUSSELL J. KNOX
13. Birthplace MARYLAND

MOTHER
14. Maiden name EDNA DAVIS
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 18, 1939 (month) (day) (year)

Cemetery or crematory Beckman Cem

Location 1 mile E Dist of Vindex

18. Funeral director D. S. Bad
Address Barton, Md.

19. Sept 20 1939 (Date rec'd by registrar) Jos P. Franklin MD Registrar

MEDICAL CERTIFICATION

6:35

20. DATE OF DEATH SEPTEMBER 18, 1939 at pm M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT 16, 1939, to SEPT 18, 1939, and that I last saw him alive on SEPT 18, 1939.

Immediate cause of death Bronchopneumonia — DURATION 1 wk

Due to Flea Colitis — 1 mo.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Eliason MD
M. D. or other

Address 126 Union St Cumberland Md Date signed 9/19/39

DR. ELIASON

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

08629

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 70 E main (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Elizabeth Krause

3. (b) Social Security Number:

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Conrad Krause deceased

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 23-1873

8. AGE: Years: 65 Months: 11 Days: 11 If less than one day ____ hrs. ____ min.

9. Birthplace: Frostburg - alleg - Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: Conrad Haberlein

13. Birthplace: Germany

MOTHER

14. Maiden name: Caroline Eberly

15. Birthplace: U.S.

16. Informant: Carl Krause

Address: Canton, Ohio.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 5 - 1939 (month) (day) (year)

Cemetery ~~or crematory~~: German Lutheran

Location: Frostburg, Md

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. 9-5 1939 (Date rec'd by registrar) Mrs. A. R. Haller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3 1939, at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18 1939, to Sept 3 1939, and that I last saw her alive on Sept 2 1939.

Immediate cause of death: Carcinoma of Stomach

DURATION: ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. O. McClure Jr. M.D. M. D. or other

Address: Frostburg Md Date signed: Sept 5 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08630

CERTIFICATE OF DEATH

(NO-E)

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 217 West Third Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 217 West Third Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: JOSEPH ROBERT LAGRATTA

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1939

8. AGE:

Years	Months	Days	If less than one day
-	-	2	hrs. min.

9. Birthplace: Cumberland, Alle., Md.
(Town, county, and state)

10. Usual occupation: --

11. Industry or business: --

FATHER
12. Name: JJames LagrAtta
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: ~~Rosetta~~ Eshbaugh
15. Birthplace: WestVirginia

16. Informant: James Lagretta

Address: 217 W. Third St., Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Sept. 21, 1939
(month) (day) (year)

Cemetery or crematory: St. Patrick's Cemetery
Cumberland, Maryland

Location:

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Sept. 20, 1939 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 20 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1939, to Sept 19, and that I last saw him alive on Sept 20 1939.

Immediate cause of death: Contusion of brain

Due to: Difficult Labor

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: no

DURATION: ~~Sept~~ 2 days

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 133 Va Ave Date signed: Sept 21 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(46-B)

08631

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 15 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany County

City or town: Barton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Absolom C. Lambert

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Lydia Ketterman

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 30, 1867

8. AGE: Years	Months	Days	If less than one day
71	11	2	____ hrs. ____ min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Nelson Lambert
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Mary Ann Lambert
15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 5 1939 (month) (day) (year)

Cemetery or crematory: Duckworth Cemetery

Location: 2 1/2 mi. East of Westernport

18. Funeral director: David S. Boal

Address: Westernport Md.

19. Sept. 5 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2, 1939, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23 1939, to Sept 2 1939 and that I last saw him alive on Sept 2 1939

Immediate cause of death: Cardiac Failure

Due to: age and Operation for carcinoma of stomach

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Carcinoma obstructing pylorus

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland Md. Date signed: Sept 13 39

DR. ENFIELD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08632

107-a

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days) 18 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Barton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
John Lewis Lashbaugh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife May Bacon
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1868

8. AGE: Years 71 | Months 8 | Days — | If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation W.P.A.

11. Industry or business

FATHER
12. Name Ben Lashbaugh
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Greenhorn
15. Birthplace Maryland

16. Informant Hospital Records.
Address ALEC LASHBAUGH BARTON, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 28, 1939 (month) (day) (year)
Cemetery or crematory Laurel Hill Cem.
Location Moscow, Md.

18. Funeral director David S. Boal
Address Westernport, Md.

19. Sept. 27, 39 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1939, at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-8- 1939, to 9-25- 1939, and that I last saw him alive on 9-25- 1939.

	DURATION
Immediate cause of death Bronchopneumonia	about 22 days.
Due to	
Due to Benign Hypertrophy Prostate	about 2 years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy not done

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Folgon M. D. or other
Address Cumberland, Md. Date signed 9-25-39

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

Reg. Dist. No. 9 08633

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany.

City or town Wrights Crossing
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)

State Maryland County Allegany Rural

City or town Wrights Crossing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Near Frostburg
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Baby. Lloyd.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single ~~married~~

6 (b) Name of husband or wife Mr Henry Lloyd

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 19th Sept 1939

8. AGE: Years | Months | Days | If less than one day ——hrs. ——min.

9. Birthplace Wrights Crossing Frostburg Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Mr Henry Lloyd

13. Birthplace Ford Md.

MOTHER 14. Maiden name Anna Thomas

15. Birthplace Frostburg Md.

16. Informant Henry Lloyd

Address Frostburg Md.

17. Burial Date thereof 9-19-39
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mcluskie Cemetery

Location Frostburg Md.

18. Funeral director Jonas Klumb

Address Frostburg Md.

19. 9-19 1939 Mrs. A. R. Hacker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1939, at 12 H M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——19——, to ——19——, and that I last saw h——alive on ——19——.

Immediate cause of death Stillborn — DURATION

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide —— Date of ——

Where did injury occur? —— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury —— Injured at work?

23. SIGNATURE W. E. Gatteys M.D.
M. D. or other

Address Frostburg, Md Date signed 9/19/39.

RECEIVED
OCT 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(94E)

08634

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution: Robbins Street

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 57 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Robbins Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: James Lynch

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 25, 1860

8. AGE: Years: 77 | Months: 6 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Lonaconing, Allegany Co., Md
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: Farming

FATHER
12. Name: John Lynch
13. Birthplace: Newfoundland

MOTHER
14. Maiden name: Isabel Kirkwood
15. Birthplace: Scotland

16. Informant: James Richmond
Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 28, 1939 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Sept. 28 1939 (Date rec'd by registrar) Dr. E. Dan Foley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 26 1939, at 12.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25 1939, to Sept 26 1939, and that I last saw him alive on Sept 26 1939

Immediate cause of death	DURATION
(a) Cerebral Hemorrhage	
Due to	
Due to	
Other conditions: Chronic Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: Henry Dr. Hodgson M.D.
M. D. or other

Address: Lonaconing Md Date signed Sept 27 '39

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

08635

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 749 Maryland Avenue

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 749 Maryland Avenue

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME ELMIRA FRANCES MCADAMS

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John McAdams

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 26, 1842

8. AGE: Years 97 | Months 4 | Days 0 | If less than one day ____ hrs. ____ min.

9. Birthplace: Magnolia, West Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: William House
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Susan Johnson
15. Birthplace: West Virginia

16. Informant: Robert K. Lewis
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 29, 39 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Sept. 29 1939 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

Dr. Koon

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1939, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1938, to Sept 26 1936, and that I last saw her alive on Sept. 20 1939.

Immediate cause of death: Chronic Nephritis — DURATION 5 yrs

Due to: Arterio Sclerosis — 5 yrs

Due to

Other conditions: Information of old by

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury ____ Injured at work?

23. SIGNATURE Thos. H. Koon M. D. or other

Address Cumberland Md. Date signed Sept 28 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

1939
73
184

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08636

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND, MD.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County HAMPSHIRE

City or town THREE CHURCHES Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR √

3. (a) FULL NAME MR. MILTON McDONALD

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife LAURA DELANDER

6(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) DEC. 22, 1889

8. AGE: Years	Months	Days	If less than one day
49	8	4	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation ORCHARDIST

11. Industry or business JACOB McDONALD

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden name BETTY POWNALL

15. Birthplace WEST VIRGINIA

16. Informant LAURA MCDONALD

Address THREE CHURCHES W. VA.

17. Burial (Burial, cremation, or removal. Which?) Removal Date thereof (month) Sept. (day) 29 (year) 1939

Cemetery or crematory Bethel Cemetery

Location Points W Va

18. Funeral director A Thrush's.

Address Romney W Va

19. Sept. 28 1939 (Date filed by registrar) J. P. Franklin, M.D. Registrar

DR. GRACIE

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 26, 1939 10:40 P.M. (at)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1939 to Sept 26 1939 and that I last saw him alive on Sept 26 1939

Immediate cause of death Pulmonary Embolism — DURATION

Due to Gangrenous appendicitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Gangrenous appendicitis

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. G. Gracie M. D. or other

Address Cumberland Date signed Sept 29-39

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8)

08637

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County Alleg. Co.

City or town Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME McKenzie, Baby Boy (Stillborn)

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 1, 1939

8. AGE: Years: Stillborn | Months | Days | If less than one day: hrs. min.

9. Birthplace Cumberland, Alleg. Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Wilbert McKenzie
13. Birthplace Maryland

MOTHER
14. Maiden name Nellie Wolfe
15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Md.

17. (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1939 (month) (day) (year)

Cemetery or crematory

Location Destroyed at Hospital

18. Funeral director

Address

19. Sept. 5 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1939, at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1939, to Sept. 1 1939, and that I last saw him alive on Sept. 1 1939.

Immediate cause of death Premature - (4 mths) Premature Separation of Placenta

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. K. Cowhead, M. D. or other

Address 41 - Green St. - Cumberland, Md. Date signed Sept. 1 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131)

Reg. Dist. No. 4.

CERTIFICATE OF DEATH

08638

1. PLACE OF DEATH:

(a) County Allegany.

(b) City or town Cumberland Md. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 215 W. Third St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 215 W. Third St. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Charles Henry Manges

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Rebecca (Beal) Manges

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 18, 1862

8. AGE: Years 76. Months 11 Days 25 If less than one day ____ hr. ____ min.

9. Birthplace Mt Zion Pa. (Town, county, and state)

10. Usual occupation Labor.

11. Industry or business

FATHER

12. Name Jerimiah Manges.

13. Birthplace Pa.

MOTHER

14. Maiden Name Hanna Fair

15. Birthplace Pa

16 (a) Informant Devan R. Manges

(b) Address Hyndman, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 15, 1939. (month) (day) (year)

(c) Cemetery or ~~crematory~~ Cooks.

Location Williamsburg Pa.

18 (a) Funeral director Harvey H. Zeigler

(b) Address Hyndman Pa.

19 (a) Sept 14, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 13 1939, at 2:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1939, to Sept. 13 1939, and that I last saw him alive on Sept. 12 1939.

Immediate cause of death Cereberal Hemorrhage — Duration 24 hrs.

Due to Hypertension — several yrs.

Due to Chronic Nephritis — 3 yrs.

Other conditions none

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature] M. D. or other

Address Cumberland Md. Date signed 9/14-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 6 1939
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(948)

CERTIFICATE OF DEATH

08639

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Detached

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 65 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Detached
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Margaret M. Gillespie Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8 (b) Name of husband or wife Wm. P. Miller

6(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) May 15, 1866

8. AGE:

Years	Months	Days	If less than one day
73	4	12	___ hrs. ___ min.

9. Birthplace Dublin, Ireland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Andrew Gillespie

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden name Anne Callahan

MOTHER 15. Birthplace Ireland

16. Informant Mrs. L. J. Shircliffe

Address Westernport, Md.

17. Burial Date thereof Sept. 30 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery Allegany

Location Frostburg, Md.

18. Funeral director M. Eichhorn

Address Lonaconing, Md.

19. Sept 30 1939 Dr. E. Dyn Taylor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1939, at 4:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1939, to Sept 27 1939, and that I last saw h[illegible] alive on Sept. 26 1939

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE R. M. Shelton, Jr. M. D.
M. D. or other

Address Midland, Md. Date signed 9-29-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

08640

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 27 DAYS
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town near FLINTSTONE Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MR. DEWEY MORRAL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
40			hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation LABORER

11. Industry or business

FATHER 12. Name AMOS MORRAL
13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name HENRIETTA LONG
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22 '39 (month) (day) (year)
Cemetery or crematory Oakdale Cem. Pa.
Location East Flintstone Md.

18. Funeral director Lonis Stein Inc.
Address Cumberland Md.

19. Sept 22 1939 Jos. P. Franklin M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 20, 1939, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG. 23, 1939 to SEPT. 20, 1939, and that I last saw h- im alive on SEPT 20, 1939

Immediate cause of death Chronic Myocarditis — DURATION

Due to

Due to

Other conditions Chronic Nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Richard J. Williams M.D.
M. D. or other
Address 34 Va. Ave. Date signed 9/25/39
Cumberland, Md.

DR. R. WILLIAMS

RECEIVED
OCT 4 1939
BUREAU V. B.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(45-B)

08641

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 125 West Second Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 125 West Second

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME (Mrs.) MARY E. MORRIS

3. (b) Social Security Number

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife William H

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1880

8. AGE: Years 59 Months 6 Days 13 If less than one day hrs. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER 12. Name James Cartwright

13. Birthplace England

MOTHER 14. Maiden name Mary Cawley

15. Birthplace England

16. Informant William H. Morris

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 30, '39 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Sept. 29 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1939, at 12:35 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1937, to Sept 28 1939, and that I last saw her alive on Sept 29-39

Immediate cause of death Cachexia.

Due to carcinomatosis

Due to carcinoma of tongue & neck, 3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations ✓

✓

✓

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. G. Cawhern M. D. ~~or other~~

Address Cumberland Date signed Sept 29-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

08642

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1305 Frederick St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Girl Noe

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: None

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Stillborn September 1, 1939

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Harry Noe

13. Birthplace: West Virginia

MOTHER — 14. Maiden name: June Leonard

15. Birthplace: Maryland

16. Informant: Memorial Hospital

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 5 39 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland, Md

19. Sept. 5 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1, 1939, at 8:5? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from at Birth, to 19; and that I last saw h alive on 19.

Immediate cause of death	DURATION
Still Born	
Due to Premature Separation of Placenta & Premature gestation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. C. Bowen M.D.
M. D. or other

Address: Cumberland Date signed 9-1-39

DR. BOWEN

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-a)

08643

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 years

Stay in this community (yrs., or mos., or days): 88 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Allegany Hospital
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: MICHAEL NOLAN

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years 88 | Months | Days | If less than one day hrs. min.

9. Birthplace: Cumberland, Maryland, Allegany
(Town, county, and state)

10. Usual occupation: Retired--carpenter

11. Industry or business

FATHER
12. Name: James Nolan
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Allegany Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13, 1939 (month) (day) (year)

Cemetery or crematory: St. Patrick's Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Sept 12 1939 (Date rec'd by registrar) Jos P. Franklin MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 10 1939, at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1938, to Sept 10 1939, and that I last saw him alive on Sept 10 1939.

Immediate cause of death: Acute suppression of urine

Due to: Not due to benign prostatic enlargement; not due to cancer. C.W.G.R.

Due to: Kidneys simply ceased to function.

Other conditions: Acute Cold. Senility
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 7 days

7 day

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. C. Bowen M.D. M. D. or other

Address: Cumberland Md Date signed 9-11-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08644

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 511 Oldtown Road, East
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 511 oldtown Road, East
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: MARY JANE NOLTE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Herman A. Nolte
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept ?

8. AGE: Years	Months	Days	If less than one day
78	?	?	hrs. min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: Hugh McPheleny
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary S. ??
15. Birthplace: Ireland

16. Informant: Miss Mathilda Ruppenkamp
Address: 511 Oldtwon Road, Cumb'd, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 20, 1939 (month) (day) (year)
Cemetery or crematory: St. Patrick's Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Sept. 19, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 17 1939, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1939 to Sept 17 1939 and that I last saw h[illegible] alive on Sept 14 1939

Immediate cause of death: Cerebral Embolism — DURATION: 3 hrs.
Due to: Age
Due to: Coronary Occlusion — Sept 73
Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: No Injured at work?

23. SIGNATURE: M. D. Owens M. D. or other
Address: 133 Va Ln Date signed: Sept 19 39

RECEIVED
OCT 6 1939
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (72-a)

08645

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Eastman Rd. R.F.D.#3, Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 5th house on left side
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 11 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. RFD#3
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Robert Odgers WILLIAM ROBERT ODGERS
3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) February 18, 1928
8. AGE: Years 11 Months 6 Days 19 If less than one day hrs. min.
9. Birthplace Ridgeley, W. Va. (Town, county, and state)
10. Usual occupation Student
11. Industry or business
FATHER 12. Name Harry C. Odgers
13. Birthplace Frostburg, Md.
MOTHER 14. Maiden name Violet Saville
15. Birthplace Paw, Paw, W. Va.
16. Informant Harry C. Odgers
Address Cumberland, Md., RFD#3
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept, 8, 1939 (month) (day) (year)
Cemetery or crematory Three Churches Cemetery
Location Three Churches, W. Va.
18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland
19. Sept. 7 1939 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1939, at 10:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8, 1939, to Aug. 31, 1939, and that I last saw him alive on Aug 31 1939.

	DURATION
Immediate cause of death Gastric and nasal hemorrhage	7/10/39
Due to Acute Lymphatic leucemia	7/4/39
Due to	
Other conditions Genital hypoplasia (Include pregnancy within 3 months of death)	1935

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. B. Moore M.D. M. D. or other
Address Medical Bldg Date signed 9/6/39

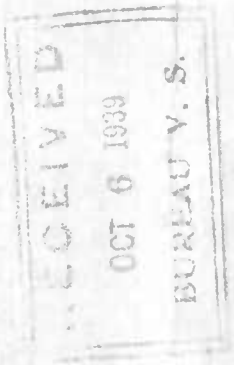
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr Grove
Wm Robert-Odgers
Died 10:30.

RECEIVED
OCT 6 1939
BUREAU V. S.



Outside of City Limits

08646

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46-C

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Locust Grove, Cumberland, Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Sara Ours

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Late Jacob Ours.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25, 1851

8. AGE: Years 87 Months 8 Days 18 If less than one day hrs. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation at Home

11. Industry or business

FATHER
12. Name John Ours
13. Birthplace West Virginia

MOTHER
14. Maiden name Mary Rice
15. Birthplace West Virginia

16. Informant Mrs Daisy Kidney

Address Bridgeport Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 16, 1939 (month) (day) (year)

Cemetery or crematory Mill Creek Church

Location Petersburg, West Virginia

18. Funeral director V. L. Lempereur

Address Greene Street

19. Sept 15 1939 (Date rec'd by registrar) Jos. F. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ? 1938, to Sept. 13 1939 and that I last saw her alive on Sept. 7 1939.

Immediate cause of death Carcinoma Sigmoid

DURATION ?

Due to

Due to

Other conditions Polyphasis of Sigmoid

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W Royce Hodges M. D. or other

Address Cumberland, Md Date signed 9/15/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

T

Mrs Ouro Lodge
Locust Grove

RECEIVED
OCT 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (200-C) Reg. Dist. No. 9

08647

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Eckhart
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Eckhart Md
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Kay Pake.

3 (b) If veteran, name war | 3 (c) Social Security No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 - 29 - 1939

8. AGE: Years — | Months — | Days 26 | If less than one day hr. min.

9. Birthplace Eckhart - Md
(Town, county, and state)

10. Usual occupation

11. Industry or business —

FATHER
12. Name Wilson Henry Pake
13. Birthplace Eckhart Md

MOTHER
14. Maiden Name Gladys Irene Wyatt
15. Birthplace Wellersburg, Pa

16 (a) Informant W. H. Pake
(b) Address Eckhart, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9 - 18 - 39 (month) (day) (year)
(c) Cemetery or crematory Wellersburg Pd -
Location Getz Cem.

18 (a) Funeral director Wilson Henry Pake
(b) Address Eckhart - Md -

19 (a) 9-17-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 17 - 1939, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on 19 .

Not at all -

Immediate cause of death | Duration

Due to Baby found

Due to dead in bed -

The physician positively does not know the cause of death.

Other conditions No more obtainable. C.W.S.P.O.
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Cohen
M. D. or other

Address Frostburg, Md. Date signed Sept. 17-39

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 3 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08648

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY COUNTY

City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days): 3 Days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: LONACONING, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

BABY GIRL RAE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): SEPT. 27, 1939

8. AGE:

Years	Months	Days	If less than one day
		3	hrs. min.

9. Birthplace: MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: JAMES RAE
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: MARY WILSON
15. Birthplace: MARYLAND

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1. 39 (month) (day) (year)

Cemetery or crematory: St. Mary Cemetery

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Sept. 30 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT 30, 1939 2:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 27 1939 to SEPT 30 1939, and that I last saw h- er alive on SEPT 30, 1939.

	DURATION
Immediate cause of death: Cerebral hemorrhage caused by forceps when attempt made to deliver at home	
Due to: Aspiration pneumonia.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Knight Reynolds M.D. M. D. or other

Address Cumberland Md Date signed Sept 30/39.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. REYNOLDS

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(145a)

CERTIFICATE OF DEATH

08649

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary Rae

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: James Rae

6(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): October 30, 1916

8. AGE: Years	Months	Days	If less than one day
22	11	0	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER
12. Name: Howard Wilson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mae Duvall
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4 39 (month) (day) (year)

Cemetery or crematory: St. Marys Cemetery

Location: Lonaconing Md

18. Funeral director: W. Eichelberger

Address: Lonaconing Md.

19. Sept. 30 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30. 1939, 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 27 1939 to Sept 30 1939, and that I last saw her alive on Sept 30 1939.

Immediate cause of death	DURATION
Puerperal septicemia	
General peritonitis following	
Cesarean section.	
Due to Forceps delivery attempted	
at home before patient admitted	
Due to to hospital. In later 4 days	
before admission.	

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations: Cesarean Section Sept 29/39
Uterus Infected before operation
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Knight Reynolds MD
M. D. or other

Address: Cumberland Md Date signed: Sept 30/39

DR. REYNOLDS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

Outside of City Limits

08650

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland R.F.D. 4
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland R.F.D. 4 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. #4
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George A. Reed

3. (b) Social Security Number 212-18-1630

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen Snyder

6(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.): Sept 5, 1892

8. AGE:

Years	Months	Days	If less than one day
47	0	25	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer + W.P.A.

11. Industry or business

FATHER
12. Name: Mr. John T. Reed
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Gross
15. Birthplace: Maryland

16. Informant: Mrs Helen Reed

Address: Cumberland, Md. R.F.D. #4

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Oct 4, 1939
(month) (day) (year)

Cemetery or crematory: Davis Memorial

Location: Cumberland - RFD #4

18. Funeral director: V. L. Lempereur

Address: 202 Green Street

19. Oct. 2, 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30, 1939 about 6:40 P.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19

Immediate cause of death: Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Linnie H. Conon, M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 10/1/39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(131)

08651

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 3 Days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Williams Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: John M. Rice

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B (b) Name of husband or wife: Maria Wilson
B(c) If alive, give age: 90 years

7. Birth date of deceased (mo., day, yr.): Apr. 28, 1855

8. AGE:

Years	Months	Days	If less than one day
84	4	20	____hrs. ____min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Thomas B. Rice
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Bucy
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 21, 1939 (month) (day) (year)
Cemetery or crematory: Mt. Pleasant Cem.
Location: Baltimore Pike

18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. Sept. 21 1939 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

Dr. Hodges

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1939, at 12:23 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to Sept. 19 1939, and that I last saw him alive on Sept. 19, 1939.

Immediate cause of death	DURATION
Due to: Chronic Nephritis	?
Due to: Bronchopneumonia	4 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: C R Hodges, Jr., M.D.
Address: Cumberland, Md. M. D. or other
Date signed: 9/19/39

RECEIVED
OCT 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08652

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
9 Furnace street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 6 weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County

City or town Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 435 Duncan Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Washington Russell

3. (b) Social Security Number

4. Sex: male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Annie Burton Russell

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 8. 1846.

8. AGE: Years: 93. Months: Days: 25. If less than one day: hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Railroad

FATHER
12. Name: Not Known.
13. Birthplace

MOTHER
14. Maiden name: Annie Paul
15. Birthplace: Scotland

16. Informant: Mrs. James McIntyre
Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 6 1939. (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery.

Location: Lonaconing Md.

18. Funeral director: David S. Boal.

Address: Lonaconing Md.

19. Sept. 6 1939 (Date rec'd by registrar) Dr. E. Dan Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3. 1939, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1939, to Sept 3 1939, and that I last saw h[illegible] alive on Sept 3 1939.

Immediate cause of death: Carcinoma of Prostate — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Henry M. Hodgson M.D.
M. D. or other

Address Lonaconing Md. Date signed Sept 5 39

RECEIVED
OCT 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 8

CERTIFICATE OF DEATH

08653

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Lonaconing (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Scotch Hill

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 1 yr

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Lonaconing (If outside city or town limits, write RURAL and give town)

(d) Street No. Scotch Hill (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sarah Elizabeth Schriver

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry Schriver

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1853

8. AGE: Years 85 Months 9 Days 12 If less than one day hr. min.

9. Birthplace Garrett County, Md. (Town, county, and state)

10. Usual occupation House wife

11. Industry or business " "

FATHER

12. Name Silas Warnick

13. Birthplace Frostburg, Md.

MOTHER

14. Maiden Name Martha Fazenbaker

15. Birthplace Frostburg, Md

16 (a) Informant Martha E. Duckworth

(b) Address Lonaconing, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27 1939 (month) (day) (year)

(c) Cemetery or crematory Oak Hill Cemetery

Location Lonaconing Md.

18 (a) Funeral director David S. Boal

(b) Address Lonaconing Md.

19 (a) Sept 26 - 1939 (Date rec'd by registrar) (b) Dr. E. Don Taylor Registrar

MEDICAL CERTIFICATION

20. Date of death Sept 24 1939, at 11.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1939, to 9-24 1939, and that I last saw him alive on 9/24 1939.

Immediate cause of death Bronchus pneumonia

Due to Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration 3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Norman Reeves M. D. or other

Address Westernport Md Date signed 9.26.39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (207-D) VB Reg. Dist. No. 4

CERTIFICATE OF DEATH

08654

(M)

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Allegany Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Penna (b) County Somerset
(c) City or town Garrette Pa (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years ✓

3 (a) FULL NAME Elias Schrock

3 (b) If veteran, name war | 3 (c) Social Security No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/13/1900

8. AGE: Years 38 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Garrette Pa (Town, county, and state)

10. Usual occupation Labor

11. Industry or business WPA.

FATHER
12. Name Jacob Schrock
13. Birthplace Garrette Pa

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Garrette Pa

16 (a) Informant Ross Schrock
(b) Address Glenco Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4/39 (month) (day) (year)
(c) Cemetery or crematory County Cemetery
Location Cumberland Md

18 (a) Funeral director Wm H. Kight
(b) Address Cumberland Md

19 (a) Oct 2 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death September 30th. 19 39 at 6.35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on 19 .

Immediate cause of death Fracture at base of skull | Duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~ accident
(b) Date of occurrence September 30th., 1939
(c) Where did injury occur? Cumberland, Allegany Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? R and O R.R. (Specify type of place) While at work? no
(e) Means of injury fall from train

23. Signature Pierce H. Corson, M.D. M. D. or other
Address Cumberland, Md. Date signed 10/2/39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(123)

08655

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MD. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. II5 BEDFORD ST.,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR World War Veteran

3. (a) FULL NAME MR. SAMUEL SCHWAB

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife SYLVIA ROSENBAUM

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) FEB. I7, 1888

8. AGE: Years	Months	Days	If less than one day
5I	6	20	____ hrs. ____ min.

9. Birthplace EUROPE (Town, county, and state)

10. Usual occupation WHOLESALE KNIT GOODS

11. Industry or business S. Schwab & Co.

FATHER
12. Name DAVID SCHWAB
13. Birthplace EUROPE

MOTHER
14. Maiden name ROSE JOHL
15. Birthplace EUROPE

16. Informant SYLVIA SCHWAB

Address II5 BEDFORD ST., CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 8, 1939 (month) (day) (year)

Cemetery or crematory Hebrew Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19 Sept. 7 1939 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 6, 1939 19 3;45 A.M., at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1939 to Sept 6 1939, and that I last saw him alive on Sept 5 1939

Immediate cause of death Pylephlebitis — Diverticulitis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION Every Colon Weeks.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE A. H. Hawkins M. D. or other

Address Cumbd Md Date signed 9-7/39

DRS. HAWKINS & JACOBSON

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 23 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 8

CERTIFICATE OF DEATH

08656

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Ocean Md. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) —

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Ocean, Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. — (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** — Seminsky

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 4 1939

8. AGE: Years — Months — Days — If less than one day — hr. — min.

9. Birthplace Ocean, Allegany Co. Md. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name James Edward Seminsky

FATHER 13. Birthplace Midland Md.

MOTHER 14. Maiden Name Wilhelmina Seit

MOTHER 15. Birthplace Ocean Md.

16 (a) Informant James Edward Seminsky

16 (b) Address R. F. D. Frostburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 1939 (month) (day) (year)

17 (c) Cemetery or crematory Belview Cem. Midland

Location Midland

18 (a) Funeral director Jacob Hafer

18 (b) Address Frostburg

19 (a) Sept 4-1939 (Date rec'd by registrar) (b) D. E. Dan Taylor Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 4 1939, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19—, to — 19—, and that I last saw him alive on — 19—.

Immediate cause of death	Duration
Stillborn Infant	
Due to Placenta praevia	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings: —

Of operations —

Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature Henry M. Hodgen M.D. (M. D. or other)

Address Lonaconing Md Date signed Sept 4 '39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 6 1939
BUREAU V. S.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 9

CERTIFICATE OF DEATH

(8)

WITHIN CORPORATE LIMITS

WITHIN CORPORATE LIMITS 08657

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miners Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) —

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State ____ (b) County ____

(c) City or town ____ (If outside city or town limits, write RURAL and give town)

(d) Street No. ____ (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Baby Sharer

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 29 1939

8. AGE: Years | Months | Days | If less than one day

Stillborn hr. ____ min.

9. Birthplace Frostburg Md (Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER

12. Name John Sharer

13. Birthplace Cumberland Md

MOTHER

14. Maiden Name Virginia Grahame

15. Birthplace Frostburg Md

16 (a) Informant John Sharer

(b) Address Frostburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-39 (month) (day) (year)

(c) Cemetery or crematory Allegany

Location Frostburg Md

18 (a) Funeral director J. J. Durst

(b) Address Frostburg Md

19 (a) 9-30-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Sept 29 1939, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from Stillborn 19__, to 19__, and that I last saw him alive on ____ 19__.

Immediate cause of death Death of foetus in utero

Due to ____

Due to ____

Other conditions ____ (Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

Duration: 2 wk

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) ____ (County) ____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ____ (Specify type of place) While at work? ____

(e) Means of injury ____

23. Signature W. D. McLane Jr. M.D. M. D. or other

Address Frostburg Md Date signed Sept 29 1939

RECEIVED
OCT 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08658

Reg. Dist. No. 7

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: German Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 80 yrs. 11 mos. 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural - Barton Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: German St.,

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Johanna E. Creutzburg Shaw

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: James P. Shaw

6(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Oct 9, 1858

8. AGE: Years	Months	Days	If less than one day
80	11	21	hrs. min.

9. Birthplace: Barton, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Johann E. Creutzburg

FATHER — 13. Birthplace: Friedrichroda, Germany

MOTHER — 14. Maiden name: Martha Meerbach

MOTHER — 15. Birthplace: Friedrichroda, Germany

16. Informant: Mrs. James P. Shaw

Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 3, 1939 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Mycon, Md.

18. Funeral director: Mr. Eichhorn

Address: Lonaconing, Md.

19. Oct 5, 1939 (Date rec'd by registrar) J. A. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 30th 1939, at 7:15 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Sept 22nd 1939, to Sept 30th 1939, and that I last saw h alive on Sept 30, 1939.

	DURATION
Immediate cause of death: Cerebral Embolism — Pneu	1 day
Due to: Chronic Myocarditis	2 wks
Due to:	
Other conditions: Lobar Pneumonia (left)	10 days

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Norman Reeves, M.D.

M. D. or other

Address: Westernport, Md. Date signed: 10-2-39

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127) (B)

CERTIFICATE OF DEATH

08659

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 13
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNA. County SOMERSET
City or town MEYERSDALE Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME MR. CHARLES M. SMITH

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

8 (b) Name of husband or wife MARY J. MILLER
6(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) JULY 11, 1870

8. AGE: Years 69 | Months 2 | Days 14 | If less than one day ____ hrs. ____ min.

9. Birthplace PENNSYLVANIA (Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

FATHER 12. Name CHRISTOPHER SMITH
13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden name ELIZABETH HENSEL
15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept. 27, 1939 (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Meyersdale, Pa.

18. Funeral director W. C. Price
Address Meyersdale Pa.

19 Sept. 26, 1939 (Date rec'd by registrar) J. T. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 25, 1939 at 9:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT 12, 1939 to SEPT 25, 1939, and that I last saw h 1m alive on SEPT 25, 1939.

Immediate cause of death	DURATION
Diabetes, mellitus, with Arteriosclerosis and Myocardial Degeneration	?
Due to	
Due to	
Other conditions Benign Hypertrophy Prostate	1 year?
Chronic Prostatitis and Cystitis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Perrvethral Prostatic Resection 9-21-39
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Tolson M. D. or other
Address Cumberland Date signed Md.

DR. TOLSON

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH (48)

08660

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 1014 Gay St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1014 Gay St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Clara Long Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Married.

6 (b) Name of husband or wife Walter Smith

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1880

8. AGE: Years 59 | Months 5 | Days 27 | If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland, Alleg. Md.
(Town, county, and state)

10. Usual occupation House work.

11. Industry or business Private Homes

FATHER
12. Name Wm Long
13. Birthplace Montgomery County, Md

MOTHER
14. Maiden name Caroline Hagaman
15. Birthplace Frostburg, Md.

16. Informant Mary A. Long.
Address 522 Green St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3, 1939. (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery.
Location Cumberland, Md.

18. Funeral director Jacob Hafer.
Address Cumberland, Md.

19. Sept. 2, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1st 1939, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1939, to Sept. 1st 1939, and that I last saw her alive on Aug. 31 1939.

Immediate cause of death	DURATION
Cancer of the uterus.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE J. J. Langston M. D. or other
Address 546 N. Mech. St. Date signed 9-2-39

Dr Langston

RECEIVED
OCT 6 1939
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 4

CERTIFICATE OF DEATH

08661

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland RL
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Lavale

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) —

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Cumberland RL
(If outside city or town limits, write RURAL and give town)

(d) Street No. Lavale
(If rural give location)

(e) If foreign born, how long in U. S. A.? 50 years

3 (a) **FULL NAME** Robert Smith

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Isabella Black

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13-1857

8. AGE: Years 82 | Months 6 | Days 27 | If less than one day ____hr. ____min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual occupation Brass moulder

11. Industry or business Foundry & Machine

FATHER 12. Name Smith

FATHER 13. Birthplace Scotland

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Scotland

16 (a) Informant Douglas Smith

(b) Address Cumberland Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12, 1939 (month) (day) (year)

(c) Cemetery or crematory Philos

Location Westernport, Md.

18 (a) Funeral director D. E. Boal

(b) Address Barton, Md.

19 (a) 9-11-39 (Date rec'd by registrar) (b) J. A. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death September 10 1939, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1939, to Sept 10 1939, and that I last saw him alive on Sept 6 1939.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 hour
Due to Hypertension Heart Failure	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —

(e) Means of injury —

23. Signature F. Allen G. Hamilton M. D. or other

Address 41 Frame Ave Cumberland Md Date signed Sept 11 39

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131) 13

08662

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 12 Days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PENNSYLVANIA County BEDFORD

City or town CLEARVILLE Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ROUTE #2
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME WILLIAM SNYDER

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 1, 1879

8. AGE: Years 60 Months 5 Days 8 If less than one day hrs. min.

9. Birthplace PENNA.
(Town, county, and state)

10. Usual occupation FARMING

11. Industry or business

FATHER
12. Name JOHN F. SNYDER
13. Birthplace PENNA.

MOTHER
14. Maiden name BARBARA MEARKLE
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 12-1939 (month) (day) (year)

Cemetery or crematory Cemetery

Location Stephen's Chapel

18. Funeral director Stanley S. Gump

Address Everett Pa

19. Sept. 9 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 9, 1939, 9:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 28, 1939, to Sept. 9, 1939, and that I last saw him alive on 9/9/39 19

Immediate cause of death Chronic Myocarditis, Chronic Nephritis. DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard J. Williams, M.D. M. D. or other

Address 34 Va. Ave., Date signed 9/9/39

DR. W.F. WILLIAMS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 6 1939
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(8)

Reg. Dist. No. 086639

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miner's Hosp.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: W. Main Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME (FETUS) SPALLA

3. (b) Social Security Number

4. Sex: ?

5. Color or race: W

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 9/20/39

8. AGE: Years: (FETUS) – 5 WEEKS; Months; Days; If less than one day ____ hrs. ____ min.

9. Birthplace: Frostburg, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Fred Spalla
13. Birthplace: Frostburg Md.

MOTHER
14. Maiden name: Babella Minnick
15. Birthplace: Frostburg Md.

16. Informant: Mrs. Spalla

Address: W. Main Street

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 9/20/39 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 9-20 (Date rec'd by registrar) 1939 Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/20 1939, at 10 39 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/20/39 19__, to 9/20/39 19__, and that I last saw it 17 [redacted] 9/20/39 19__.

Immediate cause of death: Spontaneous abortion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: John Kilday, M.D. M. D. or other

Address: 58 W. Main St. Date signed: 9/20/39

RECEIVED
OCT 3 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 207-9

CERTIFICATE OF DEATH

508664

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Near Rawlings
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: B. & O. R. R. Tracks

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W. Va. County Preston

~~City or~~ town Newburg. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME HERBERT LEE SPANGLER

3. (b) Social Security Number 705-12-6947

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 1911

8. AGE: Years 28 Months 8 Days 7 If less than one day hrs. min.

9. Birthplace Auston W. Va.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden name Agnes Florence Spangler
15. Birthplace W. Va.

16. Informant Agnes F. Robinson
Address Newburg W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29 '39 (month) (day) (year)

Cemetery or crematory Shays Chapel Cem.

Location Newburg W. Va.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Sept. 28, 1939 (Date rec'd by registrar) M. S. Trimmeter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27th 1939, at unknown M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 .

Immediate cause of death Struck by a train — body fragmented and disembowled.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~ Railway Date of Sept. 27 1939

Where did injury occur? Near Rawlings (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) B & O R.R. tracks

Means of injury R.R. accident Injured at work? no

23. SIGNATURE Linnie H. Corson M.D. M. D. or other

Address Cumberland, Md. Date signed 9-28-39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1959
MIMEAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

08665

P.R.W.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (93-C)

County Allegany — Registration Dist. No. 6

Village or City Luke — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Elizabeth Brown Stump If U. S. Veteran, specify WAR ____

(a) Residence: No. ____ St., ____ Ward. ____

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jacob. Stump

6. DATE OF BIRTH (month, day, and year) March 5, 1862

7. AGE	Years	Months	Days	If LESS then 1 day, ____ hrs. or ____ min.
	77	6	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) 1918

11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) ____ (State or country) Scotland.

FATHER

13. NAME Robert Grant

14. BIRTHPLACE (city or town) ____ (State or country) Scotland

MOTHER

15. MAIDEN NAME Eliz. McIntyre

16. BIRTHPLACE (city or town) ____ (State or country) Scotland.

17. INFORMANT Mrs. Stump (Address) Luke, Md.

18. BURIAL, CREMATION, OR REMOVAL Place Westernport Md. Date Sept. 18, 1939

19. UNDERTAKER W. N. Fredlock (Address) Piedmont W. Va.

20. FILED Sept. 18, 1939 J. Raymond Baker M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept. 16 (Month) (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Sept. 16, 1939

I last saw her alive on Sept. 15, 1939; death is said to have occurred on the date stated above, at 1:45 A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Arthritis Deformans	1918
Other Contributory Causes of Importence: Chronic Myocarditis	1927

Name of operation None Date of ____

What test confirmed diagnosis? Physical Signs Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? None Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of Injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) Paul A. Wilson M. D.

(Address) Piedmont, W. Va.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

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Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(202-M)

08666

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or insf. (yrs., or mos., or days) 10 minutes

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany.

City or town Long Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ellis Elwood Sturtz

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1906.

8. AGE: Years 33 | Months 2 | Days 6 | If less than one day hrs. min.

8. Birthplace Pa.
(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business Orchard.

FATHER
12. Name Henry Sturtz
13. Birthplace Pa.

MOTHER
14. Maiden name Bertha Martz.
15. Birthplace Pa.

16. Informant Henry Sturtz
Address Long, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25 1939 (month) (day) (year)

Cemetery or crematory Madley Pa Cem.

Location Madley Pa.

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

19. Sept. 26 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25th 1939, at 5.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 .

Immediate cause of death fractured skull.

Due to

Due to

Other conditions frac. left humerus middle 1/3. frac. lower jaw
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~ accident Date of 9-25-1939

Where did injury occur? Bresaptown, Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) farm (orchard)

Means of injury Tractor overturned Injured at work? Yes

23. SIGNATURE Linnes H. Corson, M.D.
M. D. or other

Address Cumberland, Md. Date signed 9-25-39

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (100)

CERTIFICATE OF DEATH

08667

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 85 Ormand St. Miner's Hos.

Stay in hospital or inst. (yrs., or mos., or days) 3 weeks

Stay in this community (yrs., or mos., or days) 44 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 85 Ormand St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ellen Mary Sullivan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1895

8. AGE:

Years	Months	Days	If less than one day
44	2	28	hrs. min.

9. Birthplace Frostburg, Allegany, Md.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business At Home.

FATHER
12. Name Wm. P. Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden name Catherine E. Feldmann
15. Birthplace Eckhart Md.

16. Informant Margaret Sullivan
Address 85 Ormand St. Frostburg Md

17. Burial Date thereof Sept 20, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. 9-20 19 39 Mrs. A. R. Walter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1939; at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1939 to Sept 18 1939 and that I last saw her alive on Sept 17 1939

Immediate cause of death	DURATION
Thromb. Phlebitis of both Legs with Patchy Gangrene of Both legs	7½ mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN
Please underline the cause fo which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of No

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. McCase Jr. M.D.
M. D. or other

Address Frostburg Md Date signed Sept 21 1939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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U. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08668

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 200 yds. West of Earth's Creek Bridge on Oldtown Rd.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland R.F.D. 4 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Alva A. Swanger

3. (b) Social Security Number: 220-10-2016

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Rose Kraus

6(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): August 10 - 1910

8. AGE:

Years	Months	Days	If less than one day
29	1	12	— hrs. — min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: W. P. A. Work.

FATHER
12. Name: Charles Swanger
13. Birthplace: Md.

MOTHER
14. Maiden name: Lucy Sinbaugh
15. Birthplace: Md.

16. Informant: Theodore Swanger
Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24-39 (month) (day) (year)

Cemetery or crematory: Great Capacon, W. Va.

Location: Great Capacon, W. Va.

18. Funeral director: V. L. Lemparenu

Address: Cumberland, Md.

19. Sept. 24 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 — 1939, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to ——— 19—, and that I last saw h— alive on ——— 19—.

Immediate cause of death: Crushed Skull and severed limbs — Railway accident — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 9-22-1939

Where did injury occur? now (City or town) Cumberland, (County) Allegany (State) Md.

Injured at home, farm, industry, public place (where?): on Rail-road.

Means of injury: Struck by train Injured at work? no

23. SIGNATURE: Russell H. Larson M. D.
M. D. or other

Address: Cumberland, Md. Date signed: 9-24-1939

Deputy Medical Examiner - Allegany Co.

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SEP 26 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08669

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Oldtown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Boy Unger

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: None
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 13, 1939

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Hamill Unger
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Mary Martin
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address

17. (Burial, cremation, or removal. Which?) Date thereof: Sept. 13, 1939 (month) (day) (year)
Cemetery or crematory: Destroyed at
Location: Hospital

18. Funeral director:
Address

19. Sept. 18 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13 1939, at 1:33 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 13 1939 to Sept. 13 1939, and that I last saw him alive on Stillborn 19.

Immediate cause of death	DURATION
Intrauterine Asphyxia	9-13-39
Due to Pre Eclamptic Toxemia	?
Due to Premature Separation of Placenta	9-13-39
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arthur T. Hayes M.D.
M. D. or other
Address: 40 N. Liberty St. Date signed: 9-13-39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15

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OCT 6 1939
BUREAU V

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

CERTIFICATE OF DEATH

08670

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 4 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Oldtown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. #1
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

WELSH, BABY BOY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 15, 1939

8. AGE:

Years	Months	Days	If less than one day
		4	hrs. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name WELSH, WALTER
13. Birthplace PENNA. Hyndman

MOTHER
14. Maiden name YONKER, GOLDIE
15. Birthplace MD. Orleans

16. Informant MEMORIAL HOSPITAL
Address Cumberland, Md.

17. Burial Date thereof Sept 20, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Oldtown, Md.

18. Funeral director Jacob Hafer.
Address Cumberland Md.

19. Sept 20 1939 Jos. S. Franklin MD
(Date rec'd by registrar) Registrar

DR. A. JONES

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 19, 1939, at 4:21 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 1939, to Sept. 19 1939, and that I last saw h[illegible] alive on Sept. 19 1939.

Immediate cause of death	DURATION
Prematurity (About 38 weeks gestation)	9-15-39
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Jones M. D.
M. D. or other

Address 40 N. Liberty St. Date signed 9-19-39

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OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH (159)

08671

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 hr.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Allegany Hospital

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Boy Williams

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 9.28.39.

8. AGE: Years: 0 Months: 0 Days: 0 If less than one day: 3 hrs. 48 min.

9. Birthplace: Cumberland Maryland (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Elwood Leroy Williams

13. Birthplace: Pa.

MOTHER 14. Maiden name: Mary Virginia Kutzler

15. Birthplace: Pa.

16. Informant: Mr. Mary Williams

Address: 215 So. Ave. Cumberland, Md

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27-39 (month) (day) (year)

Cemetery or crematory: Elkins, W. Va.

Location: Elkins, W. Va.

18. Funeral director: V. L. Lenfaserd

Address: Cumberland Md.

19. Sept 28 1939 (Date rec'd by registrar) J. P. Franklin, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28, 1939, at 3:48 M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Sept 28 1939 to Sept 28 1939

and that I last saw him alive on Sept 28 1939

Immediate cause of death: Premature Birth — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: No Injured at work?

23. SIGNATURE: W. S. Devers M. D. or other

Address: 133 Va Ave Date signed: 9/28/39

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OCT 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(8)

086729

Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners Hosp.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg (Rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Eckhart
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: 'Fetus' Wilson
3. (b) Social Security Number

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 9/8/39

8. AGE: Years: Fetus | Months: | Days: 8 wks | If less than one day: ____ hrs. ____ min.

9. Birthplace: Frostburg, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Charles Wilson
13. Birthplace: Garrett County, Md

MOTHER
14. Maiden name: Evelyn Loar
15. Birthplace: Barrelsville, Md.

16. Informant: Evelyn Wilson
Address: Eckhart Mines, Md.

17. Cremate (Burial, cremation, or removal. Which?) Date thereof 9/8/39 (month) (day) (year)
Cemetery or crematory
Location

18. Funeral director
Address

19. 9 — 9 (Date rec'd by registrar) 1939 Mrs. A. R. Haller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/8/39 19__, at 11:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/8 1939, to 9/8 1939, and that I last saw h 17 ~~alive on~~ 19__

Immediate cause of death: Spontaneous abortion
Due to
Due to
Other conditions
(Include pregnancy within 8 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: John Kilday, M.D.
M. D. or other
Address: 56 W. Main St. Date signed 9/9/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(149-a)

CERTIFICATE OF DEATH

08673

4

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 week

Stay in this community (yrs., or mos., or days) 36 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 701 Fayette

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lillian Yost — Mrs. Lillian Marie Yost

3. (b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced Married

B (b) Name of husband or wife Harry L Yost

6(c) If widow, give age 36 years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1903

8. AGE: Years 36 | Months 8 | Days 10 | If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland, Maryland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER 12. Name Harvey L. Hamilton

13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Mathilda Mitt

15. Birthplace Cumberland, Md.

16. Informant Mr. Harvey Hamilton

Address Cumberland, Md.

17. Burial — Date thereof Sept. 30, '39

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter & Paul Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Sept. 29 1939 — J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1939, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1939, to Sept 28 1939, and that I last saw h— alive on Sept 28 1939.

Immediate cause of death	DURATION
Perforated Duodenal ulcer	2 days
acute dilatation of Stomach	2 days
Due to Caesarian Section Sept 23-39	
Due to Malpresentation of Pelvis and Prolonged Labor	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operation

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. Allen G. Manning M.D.

M. D. or other

Address 41 Greene St Date signed Sept 28 39

Cumberland Md

RECEIVED
OCT 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131)

Reg. Dist. No. 4

08674

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 210 Harrison St.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(d) Street No. 210 Harrison St. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs. Eliza Alice Young

3 (b) If veteran, name war No

3 (c) Social Security No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Samuel D. Young

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1856

8. AGE: Years 83 Months 8 Days 3 If less than one day hr. min.

9. Birthplace Allegany Co. Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George W. Barnes

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Mary Constantislantz

15. Birthplace Germany

16 (a) Informant Miss. Sarah Barnes

(b) Address 210 Harrison St. Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23, 1939 (month) (day) (year)

(c) Cemetery or crematory Hillcrest Cem.

Location Baltimore, Pike

18 (a) Funeral director J. C. Wolford

(b) Address Cumberland, Md.

19 (a) Sept 22, 1939 (Date rec'd by registrar) (b) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 21, 1939, at 7:30A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1939, to Sept. 21 1939, and that I last saw him alive on Sept 20 1939.

Immediate cause of death Uremic Coma — Duration 2 days

Due to Chronic Nephritis — 4 yrs

Due to Artery Sclerosis — 4 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thos. H. Kaan M. D. or other

Address Cumberland, Md Date signed Sept. 25 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 6 1939
BUREAU V. S.

08675

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 146 W. Main St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 146 W. Main St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Brode Yungerman

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband or wife Justus Yungerman.

6(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1861

8. AGE: Years 77 Months 11 Days 2 If less than one day ___ hrs. ___ min.

9. Birthplace accident Md.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business at Home.

FATHER
12. Name Daniel Brode
13. Birthplace Germany

MOTHER
14. Maiden name Minnie Miller
15. Birthplace Germany.

16. Informant Rosella Yungerman

Address Frostburg Md

17. Burial Date thereof Sept 8, 1939.
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. Sept. 8 1939 mrs A. R. Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1939, at 3:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1939, to Sept 5 1939, and that I last saw her alive on Sept 5 1939

Immediate cause of death Arteria Sclerosis Senility

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

DURATION
?
?

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. O. McLane Jr. M.D.
M. D. or other

Address Frostburg Date signed Sept 5 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. McLaine

RECEIVED
OCT 3 1939
BUREAU V. S.